

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6483

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **Alexian Hosp. Hospital**) Registered No. **1295**
 St. Ward (.....)

2. FULL NAME

Louis H. Loepfe
 (a) Residence No. **3309 Chippewa St. 161** Ward.
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male		4. COLOR OR RACE White		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Loepfe					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 4 - 1878					
7. AGE		YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
		51	6	1	
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work Mechanic					
(b) General nature of industry, business, or establishment in which employed (or employer) Tool Die Works					
(c) Name of employer					
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana					
PARENTS	10. NAME OF FATHER Louis Loepfe				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Switzerland				
	12. MAIDEN NAME OF MOTHER Walsenion				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Indiana				
14. INFORMANT Anna Loepfe (Address) 3309 Chippewa St					
15. FILED 1919 Mar 2 St. Louis REGISTRAR					

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb 5 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Jan 20** 19**30**, to **Feb 5** 19**30**
 that I last saw him alive on **Dec 5** 19**30** and that death occurred, on the date stated above, at **8:45 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Inflammation of the Gallbladder & Chronic Cholecystitis

93C
90B
127B (duration) **3** yrs. mos. ds.
 CONTRIBUTORY **Acute Pericarditis** (SECONDARY) (duration) yrs. mos. **6** ds.

18. WHERE WAS DISEASE CONTRACTED? **MO**
 IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....
 WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **X-Ray & symptoms**
 (Signed) **Frank G. Stange** M. D.
2/6, 1930 (Address) **8924 Belmont St. St. Louis**

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **St Hope** DATE OF BURIAL **Feb 8 1930**

20. UNDERTAKER **Wacker Helderle** ADDRESS **23315 Bldg**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

63
2
26
2

